



Headache Questionnaire

PATIENT'S NAME: _____ **DATE:** _____

Please answer the following questions **if** you suffer from headaches

How long have you suffered from headaches? _____ weeks/months/years

How often do you have headaches?

1-2 monthly 1-3 weekly 3-5 weekly Daily

Please circle the location of your headaches:

Eyes: right/left Temples: right/left Back of Head Top of Head Cheeks: right/left Forehead: right/left

Please circle the number that represents the **minimum, maximum** and **average** severity of your pain:

Mild 1 2 3 4 5 6 7 8 9 10 Severe

Circle all the types of pain you experience:

Constant Pounding Dull Sharp Pressure

What time of day do you usually get headaches? Morning Afternoon Night There is no pattern

Do you have allergies? _____ Seasonal Only? _____ Year Round? _____

Are your headaches seasonal? _____ Season(s): _____

Are your headaches associated with:

Menstrual cycle Allergy/Sinus problems Cold/Flu Weather Changes Altitude Changes

Please list all triggers that cause your headaches: _____

Do you have any of these symptoms with your headache?

Nausea Vomiting Light Sensitivity See Flashing Lights Blurred Vision Slurred Speech

Dizziness

Numbness Tingling of Arms or Legs Ringing in Ears Other: _____

The definition of sinusitis is: fever, green nasal drainage and facial pain requiring antibiotics to cure.

How many sinus infections do you get per year? _____

Do you have high blood pressure? _____ Treatment: _____

Do you have a family history of headaches? _____ Relationship: _____

Please list any nasal or facial trauma you have experienced: _____

Do you have difficulty breathing through your nose? _____
Right-sided blockage Left-sided blockage Both sides blocked

Are you congested: More than 50% of the time Less than 50% of the time About 50% of the time
Most Mornings Most Nights

Have you been diagnosed with any of the following?

Deviated Nasal Septum _____

Allergic Rhinitis _____

Nasal/Sinus Polyps _____

Facial Fracture _____

Have you seen a neurologist or other specialist about your headaches? _____

Please list their names and addresses: _____

Please list any diagnostic tests and approximate dates performed (CT Scans, MRI, etc): _____

List all past and present headache medications:

Past: _____

Present: _____

List all past and current allergy medications:

Past: _____

Current: _____

What medications or treatments make your headaches better? _____

How many days of work do you miss yearly due to headaches? _____

How many visits to the emergency room do you make yearly as a result of headaches? _____

What types of therapy (yoga, chiropractor, stimulation units, etc.) have you attempted to resolve your headaches?

Acupuncture _____

Botox Injections _____

Chiropractor _____

Herbs _____

Electrical Stimulation Units ____

Relaxation/Yoga _____

How much do you estimate your headaches cost you? *Consider medications, medical office visits, hospitalization, surgery, labs, tests, scans, etc. \$ _____ per month \$ _____ per year